Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

December 4, 2014

Mr. Francis Nolan, Administrator
Michaud Memorial Manor
47 Herrick Road
Derby Line, VT 05830-8759

Dear Mr. Nolan:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 29, 2014.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0143	A. BUILDING: _____ B. WING _____	C 10/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAUD MEMORIAL MANOR	47 HERRICK ROAD DERBY LINE, VT 05830

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R100	Initial Comments: An unannounced onsite investigation of three entity self reports, as well as a re-licensing survey, were conducted by the Division of Licensing and Protection on 10/29/14. Based on information gathered, the following regulatory violations were cited.	R100	PLAN OF CORRECTION PLEASE SEE ACCOMPANYING DOCUMENT	
R206 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to assure timely reporting to the appropriate State Agency (SA), as stated in VSA Title 33, Chapter 69, of a suspicion of Resident to Resident abuse and exploitation. (Residents #1 and #2). Findings include: Per VSA Title 33, Chapter 69, § 6903. Reporting suspected abuse, neglect, and exploitation of vulnerable adults (a) Any of the following, other than a crisis worker acting pursuant to 12 V.S.A. § 1614, who knows of or has received information of abuse, neglect, or exploitation of a vulnerable adult or who has reason to suspect that any vulnerable adult has been abused, neglected, or exploited shall report	R206	PLEASE SEE DOCUMENT PAGE 1	

R206, R206 + R224 POC accepted 12/4/14 JHammerRN/PMC

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R206	Continued From page 1 or cause a report to be made in accordance with the provisions of section 6904 of this title within 48 hours:.....(5) A hospital, nursing home, residential care home, home health agency, or any entity providing nursing or nursing related developmental disabilities; services for remuneration; intermediate care facility for adults with developmental disabilities; therapeutic community residence, group home, developmental home, school or contractor involved in caregiving; or an operator or employee of any of these facilities or agencies. Per record review, and despite staff knowledge of a previously identified concern, Resident #1, who was admitted on 11/16/11 and whose diagnoses included Alzheimer's Dementia, was repeatedly subjected to unsolicited and inappropriate sexual contact by Resident #2 on multiple occasions over a period of 10 months, some of which were not reported to the appropriate SA. Ongoing progress notes identified several separate incidents, between December of 2013 and October of 2014, in which Resident #2 targeted Resident #1 with sexually inappropriate behaviors including: looking through Resident #1's bedroom window, kissing, touching and/or fondling Resident #1. A progress note on 10/18/14 stated that staff witnessed Resident #2 with hands on Resident #1's buttocks while together in the sun room. The most recent incident was documented on 10/26/14 and stated that staff had witnessed Resident #2 fondling the breast of Resident #1 who was in his/her room in a state of partial undress while preparing for bed. Despite the ongoing behaviors there was no evidence the incidents on 10/18/14 and 10/26/14 had been reported to the SA.	R206		

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R206	Continued From page 2 Per interview, on the afternoon of 10/29/14, the facility Administrator confirmed knowledge of multiple incidents of inappropriate sexual behavior of Resident #2 targeted towards Resident #1. S/he stated that s/he felt Resident #2, who was identified without cognitive disabilities, was intentionally targeting Resident #1, because of that resident's cognitive impairment. The Administrator further confirmed that although some incidents had been reported to the appropriate SA, those that occurred on 10/18/14 and 10/26/14 had not been reported to the SA.	R206		
R208 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to assure all resident-to-resident incidents involving sexual abuse were reported to the licensing agency/State Agency (SA). (Residents #1 and #2). Findings include: Per record review, and despite staff knowledge of	R208	PLEASE SEE DOCUMENT PAGES 2 AND 3	

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R208	Continued From page 3 a previously identified concern, Resident #1, who was admitted on 11/16/11 and whose diagnoses included Alzheimer's Dementia, was repeatedly subjected to unsolicited and inappropriate sexual contact by Resident #2 on multiple occasions over a period of 10 months, some of which were not reported to the appropriate SA. Ongoing progress notes identified several separate incidents, between December of 2013 and October of 2014, in which Resident #2 targeted Resident #1 with sexually inappropriate behaviors including: looking through Resident #1's bedroom window, kissing, touching and/or fondling Resident #1. A progress note on 10/18/14 stated that staff witnessed Resident #2 with hands on Resident #1's buttocks while together in the sun room. The most recent incident was documented on 10/26/14 and stated that staff had witnessed Resident #2 fondling the breast of Resident #1 who was in his/her room in a state of partial undress while preparing for bed. Despite the ongoing behaviors there was no evidence the incidents on 10/18/14 and 10/26/14 had been reported to the SA. Per interview, on the afternoon of 10/29/14, the facility Administrator confirmed knowledge of multiple incidents of inappropriate sexual behavior of Resident #2 targeted towards Resident #1. S/he stated that s/he felt Resident #2, who was identified without cognitive disabilities, was intentionally targeting Resident #1, because of that resident's cognitive impairment. The Administrator further confirmed that although some incidents had been reported to the appropriate SA, those that occurred on 10/18/14 and 10/26/14 had not been reported to the SA.	R208		

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R224	Continued From page 4	R224		
R224 SS=E	VI. RESIDENTS' RIGHTS	R224	PLEASE SEE DOCUMENT PAGES 3 AND 4	

6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14.

This REQUIREMENT is not met as evidenced by:
Based on resident and staff interviews and record review, the facility failed to assure one of six residents in the applicable sample remained free from the abuse and exploitation by another resident of the home. (Resident #1). Findings include:

Per record review, and despite staff knowledge of a previously identified concern, Resident #1, who was admitted on 11/16/11 and whose diagnoses included Alzheimer's Dementia, was repeatedly subjected to unsolicited and inappropriate sexual contact by Resident #2 on multiple occasions over a period of 10 months. Resident #1's most recent assessment, dated 11/25/13 identified his/her cognitive patterns as moderately impaired with poor decision making capability and difficulty remembering. The resident was also noted to have hearing impairment as well as significant visual impairment. Per review of nursing and physician progress notes the resident was confused and oriented to self only. During interview on the afternoon of 10/29/14 Resident #1 was oriented to person only, not able to identify place or date and not able to carry on any sensible conversation with the surveyor.

Resident #2, admitted to the facility on 11/22/12,

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R224	Continued From page 5 had an assessment on 8/29/14 that identified him/her with modified cognitive independence with 'some difficulty in new situations'. During interview Resident #2, who was alert and oriented to person, place and time, confirmed prior physical contact with Resident #1 and denied any inappropriate physical contact with that, "since they told me not to touch [him/her] about 2 months ago." Per record review following an incident of inappropriate sexual contact between the two residents each of their care plans were updated, on 12/10/13. Resident #1's care plan identified the problem of; 'Potential for/Actual Sexual Abuse, recipient, related to Cognitive Deficit...' Resident #2's care plan identified; "Potential for/Actual Socially Inappropriate Behavior related to poor impulse control as evidenced by: sexually aggressive behavior...putting other resident(s) at clinically significant risk for physical injury...Inappropriate touching, fondling, groping of resident(s) in public and private areas...Significantly intrude on privacy of other resident(s).....Disregard for other resident(s) refusal to engage in sexual activities..." An action plan was initiated, on 12/10/13, to monitor and document the location of each of the residents on an hourly basis. However, despite the increased monitoring of both residents two incidents occurred, on 5/9/14 and 5/11/14 respectively, in which staff witnessed Resident #2 having inappropriate sexual contact with Resident #1. Following these incidents Resident #2 was referred to his/her physician for assessment of the ongoing sexually inappropriate behaviors. A physician progress note, dated 5/15/14, indicated the physician's impression was that early dementia was likely the cause of the behavior and Resident #2 was started on medication to	R224		

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R224	Continued From page 6	R224		

help inhibit the behavior. A follow up physician assessment, on 7/31/14, stated that Resident #2 had admitted his/her knowledge that the other resident(s) targeted with [Resident #2's] sexually inappropriate behaviors were cognitively impaired.

Ongoing progress notes identified several separate incidents, between July and October of 2014, in which Resident #2 targeted Resident #1 with sexually inappropriate behaviors including: looking through Resident #1's bedroom window, kissing, touching and/or fondling Resident #1. A progress note on 9/14/14 stated that staff witnessed Resident #2 with hands under the shirt of Resident #1 while together in the sun room. Following the incident Resident #1 stated "who is that (Resident #2), I don't even know (Resident #2) name..." The most recent incident was documented on 10/26/14 and stated that staff had witnessed Resident #2 fondling the breast of Resident #1 who was in his/her room in a state of partial undress while preparing for bed. Despite the ongoing behaviors there was no evidence of increased monitoring or supervision of the residents or other interventions to prevent the ongoing exploitation/abuse of Resident #1 by Resident #2.

During interview, Nurse #1 confirmed that Resident #1 was very confused and vulnerable and that Resident #2 continued to target Resident #1 with sexually inappropriate behaviors. Nurse #1 further stated that times chosen by Resident #2 to seek out Resident #1 coincided with times of decreased staff presence on the floor, such as during shift change when all staff were busy getting and receiving report.

Per interview, on the afternoon of 10/29/14, the

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R224	Continued From page 7 Director of Nursing Services and the facility Administrator both confirmed that the inappropriate sexual behavior of Resident #2 towards Resident #1 was ongoing and each also confirmed that, although staff continued to monitor Resident #2 on an hourly basis, the level of monitoring and supervision had not changed since 12/10/13. The Administrator further stated his/her belief that Resident #2 deliberately chose to seek out Resident #1 during periods of decreased staff presence on the floor. However, despite this knowledge, no action had been taken to assure ongoing staff presence on the floor to deter Resident #2's inappropriate behavior and unsupervised access to Resident #1.	R224		

Michaud Memorial Manor
47 Herrick Road
Derby Line, VT 05830
802-873-3152

November 25, 2014

Plan of Correction for Survey completed on 10/29/14

R206 SS=D
5.18 and 5.18a

1. Incidents occurring on October 18, 2014 and October 26, 2014 were reported to Adult Protective Services on November 4, 2014. A letter of acknowledgement from the Adult Protective Services was received on November 11, 2014. **(See attached)**

   Michaud Memorial Manor (Vermont Catholic Charities) follows Policy #HR00010 "Abuse, neglect, exploitation, mistreatment....of the residents is not tolerated." **(See attached)**

   All new employees receive a copy of Vermont Catholic Charities Human Resource Policies and Guidelines, and sign a verification of receipt form.

   An annual in-service education training session will be presented for all staff on Policy HR00010 and "Resident Rights" and "Recognizing abuse, neglect exploitation and mistreatment of residents". This in-service was completed March 31, 2014 and will presented again on December 4, 2014, and each year thereafter.

   A reminder and review of Policy HR # 00010 will be discussed at regularly scheduled staff meetings. This review is to begin February 15, 2015.

   All staff is required to report any sense or knowledge of abuse, neglect, exploitation and mistreatment (of any sort, including sexual and financial) to the Administrator and the Director of Nursing immediately upon recognition or suspicion of such acts upon a resident.

   All new residents are given a personal copy of the "Residential Rights" **(see attached)**. The "Residential Rights Licensing Regulation" poster is posted in the entrance way of the lobby, by the elevator, and on both floors of the facility.

   Discussion about resident rights, abuse, neglect, and exploitation will be discussed with residents at regularly scheduled monthly meetings with the Administrator. Residents will be encouraged to bring to the attention of the Director of Nursing and/or Administrator any sense or experience of abuse, neglect, exploitation or mistreatment. The administrator will meet with residents on December 18, 2014.

2. The Administrator (or his designee), and staff will notify Adult Protective Services within 48 hours of learning of any suspected, reported or alleged incident of abuse, neglect, or exploitation.

R208 SS=D
5.18 and 5.18c

Incidents occurring on October 18, 2014 and October 26, 2014 were reported to the guardian of Resident #1 and power of attorney and family member of resident #2 on November 4, 2014.

This reporting was noted in each of the resident's records.

A revised care plan for each resident to deal with these behaviors has been implemented beginning Nov. 20, 2014. **(See attached).**

Michaud Memorial Manor (Vermont Catholic Charities) follows Policy #HR00010 "Abuse, neglect, exploitation, mistreatment....of the residents is not tolerated." **(See attached)**

All new employees receive a copy of Vermont Catholic Charities Human Resource Policies and Guidelines, and sign a verification of receipt form.

An annual in-service education training session is presented for all staff on Policy HR00010, and "Resident Rights," and "Recognizing abuse, neglect exploitation and mistreatment of residents". These in-services were completed March 31, 2014 and September 11, 2014, respectively, and will both be presented again on December 4, 2014, and each year thereafter.

A reminder and review of Policy HR # 00010 will be discussed at regularly scheduled staff meetings. This review is to begin February 15, 2015.

All staff is required to report any sense or knowledge of abuse, neglect, exploitation and mistreatment (of any sort, including sexual and financial) to the Administrator immediately upon recognition or suspicion of such acts upon a resident.

All incidents of abuse, neglect, exploitation and mistreatment will be recorded in the resident's record. Families or legal representatives will be notified immediately. A care plan will be developed within 48 hours to deal with the behaviors.

All new residents are given a personal copy of the "Residential Rights" **(See attached)**. The "Residential Rights Licensing Regulation" poster is posted in the entrance way of the lobby, by the elevator, and on both floors of the facility.

Discussion about resident rights, abuse, neglect, and exploitation, and how they are handled and reported, will be discussed with residents at regularly scheduled monthly meetings with the Administrator. Residents will be encouraged to bring to the attention of the Director of Nursing and/or Administrator any sense or experience of abuse, neglect, exploitation or mistreatment. The administrator will meet with residents on December 18, 2014.

2. Beginning November 4, 2014, the Administrator (or his designee), and staff will be responsible to document and report immediately any suspected or reported incidents of any type of abuse, neglect, or exploitation to the guardians and/or appropriate family member(s) of the resident.

   Beginning November 4, 2014, the Administrator and Director of Nursing will monitor each incident and follow up with the guardian and/or family member as appropriate.

   Beginning November 4, 2014, each resident care plan dealing with a particular behavior will be monitored daily and reviewed monthly (or as required/needed).

R224 SS=E
6.12

1. Michaud Memorial Manor (Vermont Catholic Charities) follows Policy #HR00010 "Abuse, neglect, exploitation, mistreatment....of the residents is not tolerated." **(See attached)**

   All new employees receive a copy of Vermont Catholic Charities Human Resource Policies and Guidelines including "Resident Rights", and sign a verification of receipt form.

   An annual in-service education training session will be presented for all staff on Policy HR00010 and "Resident Rights". This in-services was completed March 31, 2014 and will be presented again on December 4, 2014, and each year thereafter.

   All staff is required to report any sense or knowledge of abuse, neglect, exploitation and mistreatment to the Administrator immediately upon recognition or suspicion of such acts upon a resident.

   All new residents are given a personal copy of the "Residential Rights" **(See attached)**. The "Residential Rights Licensing Regulation" poster is posted in the entrance way of the lobby, by the elevator, and on both floors of the facility.

   Discussion about resident rights, abuse, neglect, and exploitation will be discussed with residents at regularly scheduled monthly meetings with the Administrator. Residents will be encouraged to bring to the attention of the Director of Nursing and/or Administrator any sense or experience of abuse, neglect, exploitation or mistreatment. To begin December 18, 2014.

   Michaud Memorial Manor will invite the state's ombudsman to address the residents on Resident Rights, abuse and neglect. To be completed by February 27, 2015.

   The guardian for Resident #1 requests that they not be together at any time, nor is resident #2 allowed to go into resident #1 room at any time. **(See attached).** A letter from the administrator informing resident #2 of this request was presented to him, and a copy sent to his power of attorney. **(See Attached)**

2. Staff was monitoring resident # 2's location every hour. As of October 29, 2014, the staff will monitor resident #2 every thirty minutes. As a further precaution, resident #2 will be observed/monitored during shift change and report times, and after each meal time (especially after

supper hour) as to where he goes, assuring that he will not be near or in the company of resident #1; staff will continue to document.

Signed: _____ Date: 11-25-14

Administrator